NAME OF PROVIDER OR SUPPLIER HILDEGARD HEALTH CENTER INC STREET ADDRESS, CITY, STATE, ZIP CODE 802 E 10TH ST FERDINAND, IN 47532 ID PROVIDER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). ISTREET ADDRESS, CITY, STATE, ZIP CODE 802 E 10TH ST FERDINAND, IN 47532 ID PROVIDER PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION DEFICIENCY) PREFIX TAG PROVIDER PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETION DEFICIENCY) COMPLETION TAG K0000 Preparation and execution of this response and plan of correction does not constitute anadmission of agreement by the provider of the truth of the facts alleged or conclusionsset forth in the statement of deficiencies. The	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER HILDEGARD HEALTH CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). STREET ADDRESS, CITY, STATE, ZIP CODE 802 E 10TH ST FERDINAND, IN 47532 ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).			IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED	
HILDEGARD HEALTH CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). 802 E 10TH ST FERDINAND, IN 47532 ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) COMPLETION DATE K0000 Preparation and execution of this response and plan of correction does not constitute anadmission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the		15E681		B. WING		01/07/2013	
HILDEGARD HEALTH CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K0000 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). K1000 FERDINAND, IN 47532 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ON DATE (X5) COMPLETION DATE K0000 Preparation and execution of this response and plan of correction does not constitute anadmission of agreement by the provider of the truth of the facts alleged or conclusionsset forth in the	NAME OF F	PROVIDER OR SUPPLIE	R				
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). (X5) PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) NOTICE OF THE APPROPRIATE DEFICIENCY NOTICE OR TO THE APPROPRIATE DEFICIENCY NOT	LIII DEGADD LIEAL TH GENTED ING						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE		ARD HEALTH CEN	TER INC	FER	DINAND, IN 47532		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). K0000 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE K0000 Preparation and execution of this responseand plan of correction does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusionsset forth in the	1						
K0000 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). K0000 Preparation and execution of this response and plan of correction does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusions set forth in the					CROSS-REFERENCED TO THE APPROPRI	ATE	
A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). K0000 Preparation and execution of this responseand plan of correction does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusionsset forth in the		REGULATORY O	R LSC IDENTIFTING INFORMATION)	IAG	DELICE:(CT)	DATE	
and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). responseand plan of correction does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusionsset forth in the	110000						
and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). responseand plan of correction does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusionsset forth in the		A Life Safety Code Recertification		K0000	Preparation and execution of	this	
conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). does not constitute anadmission of agreement by the provider ofthe truth of the facts alleged or conclusionsset forth in the		· ·					
Department of Health in accordance with 42 CFR 483.70(a).			•				
accordance with 42 CFR 483.70(a). conclusionsset forth in the		<u> </u>					
		Ī -			_		
		accordance with 42 Cr K 403.70(a).					
Survey Date: 01/07/13 plan of correction is prepared and/orevecuted solely because it		Survey Date:	01/07/13				
and/orexecuted solely because it is required by theprovisions of		Survey Bate. 01/07/13					
		Facility Number: 004429			·		
Provider Number: 15F681 thepurposes of any allegation that		Provider Number: 15E681					
the facility isnot in substantial		AIM Number: 200502430					
AIM Number: 200502430 compliance with Federal requirements of		7.11.114111561. 200302130					
months at the street and		Surveyor: Lex Brashear, Life			-	ıd	
Safety Code Specialist plan of correction constitutes the		1			·	I	
lacility's allegation of compliance		Safety Code Specialist					
inaccordance with section 7305 of At this Life Safety Code survey. inaccordance with section 7305 of theState Operations Manual. <i>The</i>		At this Life Safety Code survey,					
noneyate via an exeted with		Hildegard Health Center Inc. was			•		
found in substantial compliance		found in substantial compliance			_		
powered generator will be		·			_		
		with Requirements for			_		
very contract of a very contract		Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of			_		
compliancere-survey							
the National Fire Protection							
Association (NFPA) 101, Life Safety							
Code (LSC), Chapter 18, New			•				
		Health Care Occupancies and 410					
IAC 16.2.		IAC 16.2.					
This facility was located on the		1					
third floor of a four story building			•				
determined to be of Type I (332)		determined to	be of Type I (332)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

	OF CORRECTION IDENTIFICATION NUMBER: 15E681	A. BUILDING B. WING	01	COMPLETED 01/07/2013		
	PROVIDER OR SUPPLIER ARD HEALTH CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 802 E 10TH ST FERDINAND, IN 47532				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
	construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 17 and had a census of 17 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/10/13. The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following:					

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Event ID: 2F7A21

Facility ID: 004429

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 01		COMPLETED		
	15E681		B. WING 01/07/2013			2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					0TH ST		
HILDEGARD HEALTH CENTER INC					NAND, IN 47532		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0046	NFPA 101						
SS=C	LIFE SAFETY CO	ng of at least 1½ hour					
		ed in accordance with 7.9.					
	18.2.9.1	ed in decordance with 7.5.					
		d review, interview	K00	46	What corrective action will be accomplished for those.	I	01/18/2013
		n; the facility failed			be accomplished for those residents found to have bee	n	
		2 battery powered			affected by the deficient	••	
	light sets were	tested monthly for			practice? The facility will te	st	
	30 seconds and	d annually for 90			the battery back up light sets i		
	minutes. LSC 1	101, Section 7.9.3			the Dining Room and over the	Э	
	requires a func	tional test shall be			generator. These tests will be		
	conducted on every required emergency lighting system at 30 day intervals for not less than 30			done monthly for 30 seconds and a ninety minute test annually.			
					2. How will you identify othe		
					residents having the potential		
	•	nnual test shall be			to be affected by the same		
					deficient practice? All		
	conducted on e				residents, visitors, and staff		
	battery powere	· ·			could be affected. The corrective action will benefit a	All	
	lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration				3. What measures will be pu		
					in place or what systemic	-	
					changes will be made to		
		itten records of			ensure the deficient practice		
	visual inspection	ons and tests shall			does not recur? Two forms	_	
	be kept by the	owner for			have been developed—one for the Dining Room battery back		
	inspection by t	he authority having			lights and one for the battery	uρ	
	jurisdiction. N	FPA 110, Section			back up light over the generat	or.	
	5-3.1 requires	EPS (Emergency			The forms have a place to		
	Power Supply)	equipment			indicate the type of test (30	_4_	
		be provided with			second or 90 minute), the day of the test, and the name of the		
	battery powere				person conducting the test.		
	· ·	deficient practice			30 second testing will be		
		residents, as well			monthly. The 90 minute test w		
		itors in the dining			be done annually. The tests	will	
		ntors in the uning			documented on the forms developed. 4. How will the		
	room.				ueveloped. 4. now will the		

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Event ID: 2F7A21

Facility ID: 004429

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETE		TED			
	I 15F681		B. WIN			01/07/20	013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				802 E 1	0TH ST		
HILDEGARD HEALTH CENTER INC			FERDINAND, IN 47532				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					corrective actions be		
	Findings includ	de:			monitored to ensure the deficient practice will not		
					recur? Audits will be		
	Based on revie	w of the		done monthly by the		ctor of	
	Preventative M	aintenance			Maintenance or his designee a		
		n on 01/07/13 at			reported at the April Quality		
	10:30 a.m. wit				Assurance Committee meeting	g.	
		nt, there was no			The QA Committee will determine if future audits are		
		n to show the two			needed at the April meeting.		
					, , , , , , , , , , , , , , , , , , ,		
	-	p light sets, one					
	located in the Dining Room and						
	one over the generator had been						
	tested monthly for thirty seconds						
	and a ninety minute annual test						
	within the past twelve months.						
	Based on interview at the time of record review, the Facility Manager said the battery back up light set at the generator was tested monthly, however, there was no						
	• •	documentation available to show a					
	thirty second monthly test and a						
	· · · · · · · · · · · · · · · · · · ·						
	-	ninety minute annual test in the past twelve months. Based on					
	· -						
	observations between 11:00 a.m.						
	and 12:30 p.m. during a tour of						
	the facility with the Facility						
	Manager, the two battery back up						
	light sets did li 	ight up when tested.					
	3-1.19(b)						
	5 1.15(6)						

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Event ID: 2F7A21

Facility ID: 004429

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	BUILDING . WING	01	COMPLETED 01/07/2013
	802 E 1	OTH ST	
E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
weekly and o minutes per NFPA 99. v and ailed to omentation l providing and NFPA es, monthly or set shall NFPA 110, gency and s. NFPA enerator sets e shall be ting than 30 ncy Power e rating at nimum of of 3-5.4.2 rd of ce, repairs shall d and o by the iction. This	K0144	K 144 Generators inspecte weekly and exercised under load 30 minutes per month. The generator is operated with Diesel power. The Diesel powered generator will be tested annually with a load bank test. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were been annual minimum 2 hour load bank test by Cummins Crosspoint, Evansvil IN. The first test will be completely January 22,2013. Future to will be each yearin January. 2 How will you identify other residents have the potential be affected by the same deficient practice? All residents could be affected. The corrective action will benefit a 3. What measurers will be printo place or what systemic changes will be made to ensure that the deficient practice does not recur? A minimum 2-hour load bank test has been scheduled with Cummins Crosspoint in Evansville, IN, for each January 2013. How will correction actions to	er .ith re d c vill lle, eted ests I to The all. but st
The Transfer Alvor Andrews Chaire Company and the Figure Company and	TOF DEFICIENCIES BE PRECEDED BY FULL FIFYING INFORMATION) INDARD weekly and 0 minutes per NFPA 99.	STREET A 802 E 1 FERDIN FOF DEFICIENCIES BE PRECEDED BY FULL FIFTYING INFORMATION) NDARD Weekly and O minutes per NFPA 99. W and Failed to Lumentation I providing Cy lighting and NFPA ies, monthly or set shall NFPA 110, gency and Is. NFPA enerator sets ID PREFIX TAG K0144	STREET ADDRESS, CITY, STATE, ZIP CODE 802 E 10TH ST FERDINAND, IN 47532 ID PREFIX FERDINAND, IN 47532 ID PROVIDERS PLAN OF CORRECTION GEACTIC CORRECTION AND SHOULD BE GEACTIC CORRECTION CORRECTION GEACTIC CORRECTION AND SHOULD BE GEACTIC CORRECTION CORRECTION GEACTIC CORRECTION CROSS-REFERENCES TO THE APPROPRIA CROSS-REFERENCES TO AND SHOULD BE GEACTIC CORRECTION. CROSS-REFERENCES TO THE APPROPRIA CROSS-REFERENCES TO THE APPROPRIA CROSS-REFERENCES TO THE APPROPRIA CROSS-REFERENCES TO THE APPROPRIA CROSS-REFERENCES. THE APPROPRIA CROSS-REFERENCES TO

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Event ID: 2F7A21

Facility ID: 004429

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		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01	COMPLETED	
15E681			B. WING		01/07/2013
NAME OF F	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
LIII DECARD LIEALTH CENTER INC				10TH ST	
HILDEGA	ARD HEALTH CEN	TER INC	FERDI	NAND, IN 47532	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		,	TAG	monitored to ensure the	DATE
	ŕ	vell as staff and		deficient practice will not	
	visitors in the	racility.		recur? The Director of	
				Maintenace will perform an A	udit
	Findings include	de:		each January to see that the	
		6.1 6 11. 1		annual load bank test is completed and documented.	
		w of the facility's		55mpiotoa ana accumentoa.	
	_	on 01/07/13 at			
	9:45 a.m. with	· ·			
	_	ent, the generator			
	log form docu				
	generator was tested weekly under load, however, there was no				
	documentation on the form that				
	showed the generator was				
	exercised und	er operating			
	conditions or i	not less than 30			
	percent of the	Emergency Power			
	Supply (EPS) nameplate rating for				
	a minimum of 30 minutes. During				
	an interview at	the time of record			
	review, the Fac	ility Manager			
	confirmed the	weekly generator			
	log did not inc	lude documentation			
	the generator	was exercised under			
	operating cond	ditions or not less			
	than 30 percer				
	-	ng for a minimum			
	of 30 minutes.				
	3.1-19(b)				

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